U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 16 October 2003

Case No: 2001-BLA-0549

In the Matter of

LEO W. AMBROSE

Claimant

v.

SIMCO-PEABODY COAL COMPANY

Employer

OLD REPUBLIC INSURANCE COMPANY

Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Party-in-Interest

APPEARANCES:

Rick Rauch, Esq.
HARRISON & MOBERLY, LLP
Indianapolis, Indiana
For Claimant

Scott A. White, Esq.
WHITE & RISSE, LLP
St. Louis, Missouri
For the Employer/Carrier

BEFORE: RUDOLF L. JANSEN
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 et seq. Under the Act, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis, commonly known as black lung, is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. § 902(b).

On February 28, 2001, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Evansville, Indiana on April 2, 2003. The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. They also are based upon my observation of the appearance and demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit received into evidence has been reviewed carefully, particularly those related to the miner's medical condition. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to "DX," "EX," and "CX" refer to the exhibits of the Director, Employer, and Claimant, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. Whether the evidence establishes a change in conditions or a mistake in a determination of fact pursuant to Section 725.310;

2. Whether Claimant has pneumoconiosis as defined by the Act and regulations;

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled; and

5. Whether Claimant's disability is due to pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Claimant, Leo W. Ambrose, was born on March 12, 1924. (Tr. 16). Claimant married Marylin Bruce on March 31, 1951, and they reside together. They had no children who were under eighteen or dependent upon them at this time this claim was filed. (DX 1).

Mr. Ambrose suffers from shortness of breath. He requires the use of supplemental oxygen throughout the day and at night. Activities such as showering cause dyspnea. Mr. Ambrose cannot walk any length without becoming short-winded and can no longer hunt or fish as he had in the past. He never regularly smoked cigarettes. The record reveals that Claimant smoked cigarettes occasionally in his twenties. The physicians of record considered this to be an insignificant smoking history.

Claimant filed his application for black lung benefits on March 16, 1990 and the claim was denied. On August 31, 2000, he filed his most recent petition for modification The Office of Workers' Compensation Programs denied the request for modification on January 13, 2001. Pursuant to Claimant's request, the case was transferred to the Office of Administrative Law Judges for a formal hearing. (DX 56).

MEDICAL EVIDENCE[1]

X-ray reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
EX 20	03/16/01	07/27/01	Renn/B	Unreadable
EX 16	03/16/01	06/09/01	Meyer/B, BCR	Negative for pneumoconiosis
EX 14	03/16/01	05/24/01	Shipley/B, BCR	Unreadable

[1] The medical evidence summarized herein represents only that medical evidence submitted regarding this request for modification.

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
EX 12	03/16/01	04/29/01	Spitz/B, BCR	Negative for pneumoconiosis
EX 6	03/16/01	04/11/01	Wiot/B, BCR	Negative for pneumoconiosis
EX 20	12/15/00	07/27/01	Renn/B	Negative for pneumoconiosis
EX 18	12/15/00	07/18/01	Fino/B	Completely negative
EX 4	12/15/00	03/28/01	Spitz/B, BCR	Negative for pneumoconiosis
EX 1	12/15/00	03/20/01	Wiot/B, BCR	Negative for pneumoconiosis
DX 55	12/15/00	12/18/00	Patel/unknown	Chronic Obstructive Pulmonary Disease

"B" denotes a "B" reader and "BCR" denotes a board-certified radiologist. A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services (HHS). A board-certified radiologist is a physician who is certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. See 20 C.F.R. § 718.202(a)(ii)(C).

Pulmonary Function Studies

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
EX 8	Cook	76/68	.66	1.59		42	YES	
03/16/01			*.71	*1.76		*40		
EX 29	Houser	76/66	.62	1.51		41	NO	Severe obstruction
10/08/01			*.60	*1.75		*34		
EX 29	Houser	76/66	.72	1.78		40	NO	
10/02/00			*.98	*2.84		*35		

*post-bronchodilator values

Arterial Blood Gas Studies

Exhibit	Date	pCO2	pO2	Resting/ Exercise
EX 8	03/16/01	41.6	74	Resting
EX 8	03/16/01	45.6	67	Exercise
EX 30	12/15/00	39	72	Resting

CT Scans

Ralph T. Shipley, M.D., reviewed the March 16, 2001 CT scan. (EX 14). He found no evidence of pneumoconiosis in the CT scan, but diagnosed moderate emphysema and right lower lobe bronchiectasis. Dr. Shipley is a board-certified radiologist and B-reader.

Jerome F. Wiot, M.D., reviewed the March 16, 2001 CT scan. (EX 6). He found no evidence of pneumoconiosis, but noted the presence of "mild emphysematous change." Dr. Wiot is board-certified in Radiology and is a B-reader.

Christopher A. Meyer also reviewed the March 16, 2001 CT scan. (EX 16). Dr. Meyer noted changes consistent with emphysema, but not pneumoconiosis. Dr. Meyer is board-certified in Radiology and is a B-reader.

Joseph J. Renn, M.D., reviewed the March 16, 2001 CT scan. (EX 20). He opined that there were no "pleural or parenchymal abnormalities consistent with pneumoconiosis. Dr. Renn is board-certified in Internal Medicine, Pulmonary Disease and is a B-reader.

Narrative Medical Evidence

Robert A. C. Cohen, M.D. issued a consultative medical report on February 6, 2003. (CX 1). He considered accurate work and smoking histories. He diagnosed Claimant with pneumoconiosis based on Claimant's history of coal dust exposure, symptoms and examination findings as reported by other physicians, the results of pulmonary function studies, that Claimant had little or no response to bronchodilators, the presence of hypoxemia illustrated by arterial blood gas studies and that Claimant had no other significant exposures. Dr. Cohen

disagreed with other physicians of record who believed Mr. Ambrose suffers from asthma. Dr. Cohen found no significant bronchodilator response in the pulmonary function studies, which would indicate an asthmatic condition. He stated,

> [Mr. Ambrose] did have an improvement in his FVC on a few studies where bronchodilators were used, but several showed no change at all in FVC. He never had an improvement in FEV_1 or FEF 25-75, two very sensitive indicators of response to bronchodilators. The FVC is not a reliable indicator of response to bronchodilators without the ability to review the forced expiratory time (FET). The FVC may improve solely because the patient exhaled longer during the post bronchodilator test, or due to a deeper inspiratory effort post bronchodilator, and not because there is a true response.

(CX 1). Additionally, Dr. Cohen stated that coal dust exposure can cause asthma, or at least a type of asthma, and that the medical literature supports this assertion.

Dr. Cohen also responded to the findings of Dr. Tuteur that Claimant's respiratory impairment was caused by congestive heart failure and gastroesophageal reflux disease (GERD). He opined that the record contained no evidence that Mr. Ambrose had "significant enough myocardial damage to cause congestive heart failure." (CX 1). He also noted that the evidence contained no records of treatment for congestive heart failure. Dr. Cohen reported that the record is likewise devoid of evidence of treatment for GERD.

Regarding Mr. Ambrose's ability to perform coal mine employment, Dr. Cohen opined that the pulmonary function studies of record demonstrated a severe reduction in lung function and that Claimant lacked the respiratory capacity for coal mine work.

Peter G. Tuteur, M.D., issued a consultative medical report on December 27, 2001. (EX 22). He considered an accurate work history and found Claimant's smoking history to be "non-contributory." Dr. Tuteur found no evidence of pneumoconiosis in his review of the medical evidence. He opined that Claimant's severe airway obstruction was caused in part by GERD. Dr. Tuteur opined that arteriosclerotic heart disease also

played a part in Claimant's severe airway obstruction. (EX 22). Dr. Tuteur disagrees with other physicians of record that Mr. Ambrose's condition could be diagnosed as asthma. He explained that the pulmonary function studies do not present sufficient information for a diagnosis of asthma. Additionally, Dr. Tuteur explained that coal dust exposure was not a cause of Claimant's respiratory condition as the above conditions are not caused by coal dust exposure and Mr. Ambrose had normal lung function upon leaving his coal mine employment. Dr. Tuteur opined that Claimant is totally disabled due to his severe airway obstruction and cannot engage in coal mine employment. Dr. Tuteur is board-certified in Internal Medicine and Pulmonary Disease.

Joseph J. Renn, M.D., issued consultative reports on January 10, 2002 and January 20, 2003. (EX 25, EX 35). Dr. Renn opined that Claimant's emphysema "resulted from his years of tobacco smoking in addition to the emphysema of the aged lung…superimposed upon asthma." (EX 35). Dr. Renn stated that Claimant's obstructive defect is too severe to have been caused by coal dust exposure and cited to several medical studies to reinforce that point. In addition, Dr. Renn addressed what he believed to be inconsistencies in Dr. Cohen's report:

> [w]hereas I agree with Dr. Cohen that the FVC is not a reliable indicator of response to bronchodilators without reviewing the forced expiratory time, he has not done so and, therefore, cannot state that the bronchodilator improvement in the FVCs performed by Mr. Ambrose is unreliable. . . .
>
> Dr. Cohen seems unconcerned that the FEV_1 "never improved to normal" and that significant decline in lung function did not occur as a result of asthma. In an asthmatic it is untrue that complete reversibility of obstruction, as evidenced by normalization in the FEV_1, would occur. It has been well documented that the remodeling of the lungs in an asthmatic results in a portion of the obstructive airways disease becoming irreversible.

(EX 35). Dr. Renn is board-certified in Internal Medicine and Pulmonary Disease.

Gregory J. Fino, M.D., issued consultative medical reports on January 9, 2002 and January 17, 2003. (EX 24, 32). Dr. Fino reviewed the March 16, 2001 CT scan and found no evidence of pneumoconiosis. Regarding Claimant's obstructive lung disease, Dr. Fino opined,

> [t]he rather significant drop in his pulmonary function between 1991 and 1994 does not explain a coal mine dust-related obstruction. The drop in his pulmonary function was too rapid to be explained by coal dust inhalation. There are no acceptable studies using valid statistical analysis that would account for such a significant drop due to coal mine dust inhalation.

(EX 32). Dr. Fino diagnosed Claimant with asthma and opined that coal dust exposure was not the cause. He determined that Claimant's asthma is totally disabling. Dr. Fino is board-certified in Internal Medicine and Pulmonary Medicine.

David M. Rosenburg, M.D., issued a consultative medical report on January 20, 2003. (EX 33). Dr. Rosenburg opined that Claimant did not suffer from pneumoconiosis. He diagnosed Claimant with COPD and attributed its cause to "airway remodeling associated with a hyperactive airway state." Dr. Rosenburg explained that coal dust exposure did not cause Claimant's COPD,

> [w]hile coal dust exposure can cause COPD, in actual fact, there is no scientifically sound evidence that severe disabling COPD occurs in relationship to coal mine dust, absent the presence of complicated coal workers' pneumoconiosis. In addition, there is no scientific support for concluding coal dust exposure causes progressive COPD after a miner has been removed from the coal mine, absent complicated pneumoconiosis. While I agree pneumoconiosis can be progressive in certain individuals after coal mine exposure has ceased, the studies which have investigated this issue, report on the progression of the interstitial form of this disorder, and not COPD.

(EX 32). Dr. Rosenburg is board-certified in Internal Medicine, Pulmonary Disease, and Occupational Medicine.

David B. Cook, M.D., examined Claimant on March 16, 2001 and issued an examination report on April 20, 2001. (EX 8). He provided a full pulmonary workup, including a chest x-ray, a pulmonary function study, an arterial blood gas study and an EKG. He considered an accurate work history and that Claimant never smoked cigarettes. He diagnosed Claimant with severe obstructive airway disease based on the results of the pulmonary function study. He concluded that this condition was not caused by coal dust exposure; however, he did not explain this conclusion. He opined that Claimant does not possess the respiratory capacity to perform his former coal mine employment. Dr. Cook is board-certified in Internal Medicine and Pulmonary Disease.

The record also contains medical records from the Deaconess Hospital Black Lung Clinic in Evansville, Indiana and the Indiana University Medical Center in Indianapolis, Indiana. (EX 29, 30). These records reveal treatment given to Mr. Ambrose from May of 1997 until July of 2002 for his respiratory condition. The records report a diagnosis of emphysema and COPD, but do not contain an accounting of how that diagnosis was reached. Symptoms such as wheezing, diminished breath sounds, and exertional dyspnea were reported. Although these records illustrate the treatment Mr. Ambrose sought for his condition, I do not find the records relevant to a determination of entitlement to benefits as they do not provide the reasoning behind the diagnosis nor is an etiology for the diagnosis given.

Deposition Testimony

Dr. Renn was deposed on August 15, 2002. (EX 31). Dr. Renn opined that Claimant's respiratory condition is caused by asthma and arteriosclerotic heart disease. He based his diagnosis of asthma on reported examination findings of "prolonged expiratory phase, expiratory wheezing, rhonchi, and diminished breath sounds." (EX 31 at 13-14). Additionally, he found that "[t]he various physiologic studies were consistent with asthma…there was also significant bronchoreverisibility, and it was my belief that the most likely explanation from a respiratory standpoint was that he had asthma." (EX 31 at 14). Dr. Renn also diagnosed Mr. Ambrose with pulmonary emphysema. He speculated that the cause of the emphysema was "senile emphysema." (EX 31 at 16). Dr. Renn also opined that he believed Claimant to have a more significant smoking history

than what was related; thus, attributing the cause of Mr. Ambrose's respiratory ailments to smoking. (EX 31 at 15).

Dr. Tuteur was deposed on August 19, 2002 and February 4, 2003. (DX 28, EX 37). He reiterated his determination that GERD was the cause of Claimant's respiratory condition. He explained how GERD can cause emphysema and airway obstruction:

> [t]he chronologic progression of GERD parallels the rapid progression of airflow obstruction in this man. The mechanism and pathophysiology of GERD and emphysema is that with regurgitation of acidic material from the stomach and aspiration of that material, typically in the lower lung fields where Mr. Ambrose's emphysema is, you get acid destruction of the lung tissue and inflammation of the airways. The destruction of lung tissue is reflected in the emphysema seen on the CT scan. The inflammation of the airways is reflected at least in the one study where there was dramatic improvement following the administration of aerosolized bronchodilator and so-called bronchiole reactivity. . . .he has air flow obstruction predominantly due to chronic recurrent, albeit silent aspiration of gastric material, resulting in emphysema and inflammatory bronchitis with secondary bronchiole reactivity.

(EX 28 at 10). Dr. Tuteur disagreed with Dr. Cohen's assertion that the record contains insufficient evidence of myocardial damage.

> We have documented myocardial infarction by thallium stress test. We have documentation of ongoing coronary artery insufficiency manifested by the observation of angina pectoris at the time of that thallium stress test, first in '91 and subsequently. And one has clinical manifestations in the form of paroxysmal nocturnal dyspnea, which is not only a manifestation of heart disease, but of heart failure and congestion. . . .I think we have very excellent evidence of not only coronary artery disease, which is

> unequivocal because of the presence of a myocardial infarction that everybody agrees with, but also clinical manifestations of that condition.

(EX 37 at 8-9). Dr. Tuteur declared that the record also contains evidence that Mr. Ambrose's suffers from GERD and has been treated for that condition. Dr. Tuteur noted that the medical evidence of record does not show that Mr. Ambrose was a "closet smoker."

Dr. Rosenburg was deposed on March 3, 2003. (EX 38). In his deposition, Dr. Rosenburg opined that Claimant's respiratory impairment was unrelated to coal dust exposure. He stated,

> Mr. Ambrose basically had normal pulmonary function tests after he left the coal mines, and I think that fact is very important in this situation because he goes on to develop severe airflow obstruction, far removed whenever he had coal dust exposure, and that is something that is important to know because that just doesn't occur in relationship to coal dust exposure.

(EX 38 at 18). He opined that asthma is the cause of Claimant's respiratory impairment and that coal dust exposure does not cause asthma. He based this diagnosis on Claimant's response to bronchodilators in the pulmonary function studies administered. Furthermore, Dr. Rosenburg suggested that GERD may be a "contributing factor" to Claimant's asthma. (EX 38 at 35). Regarding Dr. Renn's speculation that Mr. Ambrose was a "closet smoker," Dr. Rosenburg stated that the evidence of record did not lead him to believe that Mr. Ambrose underrepresented his smoking history.

DISCUSSION AND APPLICABLE LAW

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. To establish entitlement to benefits under this part of the regulations, a claimant must prove by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. §725.202(d); See

Anderson v. Valley Camp of Utah, Inc., 12 BLR 1-111, 1-112 (1989). In Director, OWCP v. Greenwich Collieries, et al., 114 S. Ct. 2251 (1994), the U.S. Supreme Court stated that where the evidence is equally probative, the claimant necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence.

Modification

Claimant may establish modification by proving either a change in condition since the earlier denial or a mistake in a determination of fact had occurred in the previous decision. 20 C.F.R. §725.310. In considering whether a change in conditions has been established pursuant to Section 725.310, I am obligated to perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish the element or elements of entitlement which defeated entitlement in the prior decision. See Kovac v. BCNR Mining Corp., 14 BLR 1-156 (1990), modified on recon., 16 BLR 1-71 (1992); Wojtowicz v. Duquesne Light Co., 12 BLR 1-162, 1-164 (1989); see also O'Keefe v. Aerojet - General Shipyards, Inc., 404 U.S. 254, 256 (1971). Moreover, as the fact-finder, I have broad discretion to correct mistakes of fact, including the ultimate fact of entitlement to benefits. Keating v. Director, OWCP, 71 F.3d 1118 (3rd Cir. 1995); Jesse v. Director, OWCP, 5 F.3d 723 (4th Cir. 1993).

In the prior denial, the administrative law judge determined that Claimant did not have pneumoconiosis or any totally disabling respiratory or pulmonary disease. Therefore, I must determine whether the newly submitted evidence, in conjunction with the previously submitted evidence, establishes a change in condition. I also must review the evidence of record to determine whether the prior denial contains a mistake in a determination of fact.

Employer has conceded that Claimant is totally disabled. (Employer's Brief at 56). Thus, a change in condition has been established and I must review the entire record to determine entitlement to benefits.

Full Review of Record: Pneumoconiosis and Causation

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30

U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. See Dixon v. North Camp Coal Co., 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. See Woodward v. Director, OWCP, 991 F.2d 314, 316 n.4 (6th Cir. 1993); Sheckler v. Clinchfield Coal Co., 7 BLR 1-128, 1-131 (1984). Because pneumoconiosis is a progressive disease, I also may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. See Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-154 (1989) (en banc); Casella v. Kaiser Steel Corp., 9 BLR 1-131, 1-135 (1986).

The newly submitted evidence of record contains ten interpretations of two chest x-rays. The newly submitted x-rays are separated from the prior x-rays by at least four years. I find this to be a significant amount of time and assign the newly submitted x-rays additional weight. Of these interpretations, seven were negative, two found the March 16, 2001 x-ray unreadable and one diagnosed COPD from the x-ray. Thus, none of the newly submitted x-rays support a finding of pneumoconiosis. This is consistent with the prior evidence which was insufficient to establish pneumoconiosis. As all of the newly submitted x-ray interpretations are negative or unreadable, I find that the x-ray evidence fails to support a finding of pneumoconiosis under Section 718.202(a)(1).

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable to this claim because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions

apply to this claim, Claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides that a claimant may establish the presence of pneumoconiosis through a reasoned medical opinion. Although the x-ray evidence does not establish pneumoconiosis, a physician's reasoned opinion nevertheless may support the presence of the disease if it is explained by adequate rationale besides a positive x-ray interpretation. See Trumbo v. Reading Anthracite Co., 17 BLR 1-85, 1-89 (1993); Taylor v. Director, OWCP, 1-22, 1-24 (1986).

Of the newly submitted evidence, Dr. Cohen is the only physician to opine that Claimant suffers from pneumoconiosis. Of the earlier evidence, Drs. Daniel Combs and Joe G. N. Garcia diagnosed Claimant's with a coal dust-induced lung disease.

Dr. Cohen provided a thorough report reviewing the evidence of record. He diagnosed Claimant with pneumoconiosis and based his findings on the objective medical data of record. I find Dr. Cohen's opinion to be very well documented and reasoned and entitled to full weight. As Dr. Cohen is a pulmonary specialist, I assign his opinion additional weight.

Dr. Combs' opinion is entitled to less weight. Dr. Combs based his diagnosis of pneumoconiosis on a chest x-ray that was determined to be unreadable by highly qualified physicians. He provided no other bases for his diagnosis. Therefore, I find his opinion to be poorly documented and reasoned.

Dr. Garcia based his diagnosis of coal dust-induced pulmonary emphysema on examination findings, the results of pulmonary function studies and the results of arterial blood gas studies. I find his opinion to be well documented and reasoned and I assign it full weight.

I find Dr. Tuteur's opinion to be well documented and reasoned. Dr. Tuteur issued a very thorough and detailed medical report. He addressed the findings of the other physicians and explained his agreement or disagreement thoroughly. Dr. Tuteur's more recent opinions are consistent with his earlier opinion, although in his earlier opinion he found the evidence insufficient to make an accurate diagnosis. I find Dr. Tuteur's opinion to be well documented and reasoned and entitled to full weight. As Dr. Tuteur is a pulmonary specialist, I assign his opinion additional weight.

I find Dr. Renn's opinion to be entitled to less weight. Dr. Renn based much of his opinion on his belief that Claimant was a closet smoker. Dr. Rosenburg and Dr. Tuteur found that the medical evidence of record did not demonstrate that Claimant was a closet smoker. In addition, in my review of the record, I found the evidence insufficient to support a finding that Mr. Ambrose underrepresented his smoking history. As Dr. Renn's diagnosis and findings are based, at least in part, on his belief that Mr. Ambrose's smoking history was more significant than reported, I cannot assign his opinion full weight.

Dr. Fino diagnosed Claimant's with asthma and opined that that condition is not related of coal dust exposure. He based this opinion on the significant and rapid drop in lung function after Claimant was no longer working in the mines. Dr. Fino did not explain how asthma can result in such a significant and rapid drop. I am unpersuaded by Dr. Fino's opinion and find it to be poorly reasoned; therefore, I assign it less weight.

Dr. Rosenburg also diagnosed Claimant with COPD, which he determined was unrelated to coal dust exposure. I find Dr. Rosenburg's opinions to be inconsistent. In his January 20, 2003 written report, Dr. Rosenburg diagnosed Claimant with COPD. In his March 3, 2003 deposition, Dr. Rosenburg opined that Claimant suffers from asthma. In addition, he opined that GERD could be a contributing factor in Claimant's lung disease. The foundation of Dr. Rosenburg's opinion that Claimant does not have a coal dust-induced lung disease is that the decrease in lung function happened quickly and after Claimant had left the mines. Dr. Rosenburg does not explain how either COPD or asthma have the capability of coming on as Mr. Dalton's lung condition did. For these reasons, I find Dr. Rosenburg's opinion to be poorly reasoned and I assign it less weight.

Dr. Cook diagnosed Claimant with severe obstructive airway disease. He based this finding on the results of the pulmonary function study he administered during the physical examination. Dr. Cook determined that Claimant's impairment was not due to coal dust exposure; however, he did not explain the reasoning behind that conclusion nor offer an etiology for Claimant's condition. For these reasons, I find Dr. Cook's opinion to be poorly reasoned and entitled to less weight.

Of the earlier submitted evidence, Dr. Jeff W. Selby diagnosed Claimant with "very severe obstructive lung defect from bronchial asthma, and, potentially, emphysema." Dr. Selby opined that coal dust exposure cannot cause emphysema, which is

contrary to the position of the Department of Labor, as explained in the comments to the revised regulations. 65 Fed. Reg. 79941-42 (Dec. 20, 2000). As his opinion is at odds with the regulations, I assign his opinion less weight. Dr. William M. O'Bryan diagnosed Claimant with obstructive lung disease. He did not consider whether this condition could be caused by coal dust exposure. For this reason, I find his opinion to be incomplete and entitled to less weight.

In sum, Drs. Cohen, Combs and Garcia opined that Claimant suffers from pneumoconiosis and Drs. Cook, Fino, O'Bryan, Renn, Selby and Tuteur opined that he does not. I find Dr. Tuteur's opinion to be the better-reasoned and more persuasive opinion of record. He addressed the suddenness of Mr. Ambrose's decline in lung function. Neither Dr. Cohen nor Dr. Garcia explained this rapid decline in lung function in light of their diagnoses. I find Dr. Tuteur's opinion to be consistent with the record as a whole. Considering all the relevant factors for crediting and discrediting a physician's medical opinion, I find that the weight of the evidence of record fails to support a finding of pneumoconiosis under Section 718.202(a)(4).

Although Employer has conceded that Claimant is totally disabled, Claimant has failed to demonstrate that he suffers from pneumoconiosis. Accordingly, this claim must be denied.

ORDER

The claim of Leo W. Ambrose for benefits under the Act is hereby **DENIED**.

A

Rudolf L. Jansen
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. A copy of this Notice of Appeal also must be served on Donald S.

Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.